Dated: December 28, 2010.

Mirtha Beadle,

Deputy Director, Office of Minority Health, Office of the Assistant Secretary for Health, Office of the Secretary, U.S. Department of Health and Human Services.

[FR Doc. 2010–33084 Filed 12–30–10; 8:45 am]

BILLING CODE 4150–29–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–11–11BM]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404–639–5960 and send comments to Carol E. Walker, Acting CDC Reports Clearance Officer, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an e-mail to *omb@cdc.gov.*

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Written comments should be received within 60 days of this notice.

Proposed Project

Healthcare System Surge Capacity at the Community Level—New—National Center for Emerging and Zoonotic Infectious Diseases, (NCEZID), Centers for Disease Control and Prevention, (CDC).

Background and Brief Description

The Healthcare Preparedness Activity, Division of Healthcare Quality Promotion (DHQP) at the Centers for Disease Control and Prevention (CDC) works with other Federal agencies, State governments, medical societies and other public and private organizations to promote collaboration amongst healthcare partners, and to integrate healthcare preparedness into Federal, State and local public health preparedness planning. The goal of the Activity is to help local communities' healthcare delivery and public health sectors effectively and efficiently prepare for and respond to urgent and emergent threats.

Surge is defined as a marked increase in demand for resources such as personnel, space and material. Health care providers manage both routine surge (predictable fluctuations in demand associated with the weekly calendar, for example) as well as unusual surge (larger fluctuations in demand caused by rarer events such as pandemic influenza). Except in extraordinary cases, providers are expected to manage surge while adhering to their existing standards for quality and patient safety. Currently, health care organizations are expected to prepare for and respond to surges in demand ranging from a severe catastrophe (for example, a nuclear detonation) to more common, less severe events (for example, a worse-than-usual influenza season). The Centers for Disease Control and Prevention (CDC) and Federal agencies have dedicated considerable funding and technical assistance towards developing and coordinating community-level responses to surges in demand, but it remains a difficult task.

While there is extensive research on managing collaborations during times of extraordinary pressure where response to surge takes precedence over other activities, less is known about developing and maintaining integrated collaborations during periods where the system must respond to unusual surge but also continue the routine provision of health care. In particular, studies have not explored how these collaborations can build on sustainable relationships between a broad range of stakeholders (including primary care providers) in communities with different market structures and different degrees of investment in public health.

This study aims to generate information about the role of community-based collaborations in disaster preparedness that the CDC can use to develop its programs guiding and supporting these collaborations. This project will explore barriers and facilitators to coordination on surge response in ten communities, eight of which have been studied longitudinally since the mid-1990s as part of the Center for Studying Health System Change's (HSC's) Community Tracking Study (CTS). Interviews of local healthcare stakeholders will be conducted at 10 sites.

Interviews will be conducted at a total of 63 organizations over the two years of this project. Within each of the ten communities studied, two emergency practitioner respondents (one from a safety-net hospital and one from a non-safety-net hospital), two primary care providers (one from a large practice and one from a small practice) and two local preparedness experts (one from the County or local public health agency, and one coordinator or collaboration leader) will be interviewed. In three sites (Phoenix, Greenville and Seattle) an additional respondent will be identified from an outlying rural area to offer the perspective of providers in those communities. There is no cost to respondents except their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondent category	Number of respondents	Number of responses per respondent	Average burden response (in hours)	Total burden (in hours)
Emergency Department: Private, non-safety net	10	1	1	10
Emergency Department: Public/safety net	10	1	1	10
Primary Care: Larger practice	10	1	1	10
Primary Care: Solo/2 physician practice	10	1	1	10
Preparedness: Public/Department of Health	10	1	1	10
Preparedness: Health care preparedness coordinator/collaboration leader	10	1	1	10
Rural (Greenville, Phoenix, Seattle only: Clinician-leader at rural site (ED or PC)	3	1	1	3

ESTIMATED ANNUALIZED BURDEN HOURS—Continued

Respondent category	Number of respondents	Number of responses per respondent	Average burden response (in hours)	Total burden (in hours)
Total				63

Dated: December 27, 2010.

Carol E. Walker,

Acting Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. 2010–33128 Filed 12–30–10; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2321–N]

RIN 0938–AQ44

Medicaid Program; Final FY 2009 and Preliminary FY 2011 Disproportionate Share Hospital Allotments, and Final FY 2009 and Preliminary FY 2011 Institutions for Mental Diseases Disproportionate Share Hospital Limits

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice announces the final Federal share disproportionate share hospital (DSH) allotments for Federal FY (FY) 2009 and the preliminary Federal share DSH allotments for FY 2011. This notice also announces the final FY 2009 and the preliminary FY 2011 limitations on aggregate DSH payments that States may make to institutions for mental disease and other mental health facilities. In addition, this notice includes background information describing the methodology for determining the amounts of States' FY DSH allotments.

DATES: *Effective Date:* This notice is effective March 4, 2011. The final allotments and limitations set forth in this notice are effective for the fiscal years specified.

FOR FURTHER INFORMATION CONTACT: Richard Strauss, (410) 786–2019.

SUPPLEMENTARY INFORMATION:

I. Background

A. Disproportionate Share Hospital Allotments for Federal FY 2003

Under section 1923(f)(3) of the Social Security Act (the Act), States' Federal fiscal year (FY) 2003 disproportionate share hospital (DSH) allotments were calculated by increasing the amounts of the FY 2002 allotments for each State (as specified in the chart, entitled "DSH Allotment (in millions of dollars)", contained in section 1923(f)(2) of the Act) by the percentage change in the Consumer Price Index for all Urban Consumers (CPI–U) for the prior fiscal year. The allotment, determined in this way, is subject to the limitation that an increase to a State's DSH allotment for a FY cannot result in the DSH allotment exceeding the greater of the State's DSH allotment for the previous FY or 12 percent of the State's total medical assistance expenditures for the allotment year (this is referred to as the 12 percent limit).

Most States' *actual* FY 2002 allotments were determined in accordance with the provisions of section 1923(f)(4) of the Act which allowed for a special DSH calculation rule for FY 2001 and FY 2002. However, as indicated previously, the calculation of States' FY 2003 allotments was *not* based on the actual FY 2002 DSH allotments; rather, section 1923(f)(3) of the Act requires that the States' FY 2003 allotments be determined using the amount of the States' FY 2002 allotments specified in the chart in section 1923(f)(2) of the Act. The exception to this is the calculation of the FY 2003 DSH allotments for certain "Low-DSH States" (defined in section 1923(f)(5) of the Act). Under the Low-DSH State provision, there is a special calculation methodology for the Low-DSH States only. Under this methodology, the FY 2003 allotments were determined by increasing States' actual FY 2002 DSH allotments, rather than their FY 2002 allotments specified in the chart in section 1923(f)(2) of the Act, by the percentage change in the CPI–U for the previous fiscal year.

B. DSH Allotments for FY 2004

Section 1001(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173, enacted on December 8, 2003) amended section 1923(f)(3) of the Act to provide for a "Special, Temporary Increase In Allotments On A One-Time, Non-Cumulative Basis." Under this provision, States' FY 2004 DSH allotments were determined by increasing their FY 2003 allotments by 16 percent, and the FY DSH allotment amounts so determined were not subject to the 12 percent limit.

C. DSH Allotments for Non-Low DSH States for FY 2005, and FYs Thereafter

Under the methodology contained in section 1923(f)(3)(C) of the Act, as amended by section 1001(a)(2) of the MMA, the non-Low-DSH States' DSH allotments for FY 2005 and subsequent FYs continue at the same level as the States' DSH allotments for FY 2004 until a "fiscal year specified" occurs. The fiscal year specified is the first FY for which the Secretary estimates that a State's DSH allotment equals (or no longer exceeds) the DSH allotment as would have been determined under the statute in effect before the enactment of the MMA. We determine whether the fiscal year specified has occurred under a special parallel process. Specifically, under this parallel process, a "parallel" DSH allotment is determined for FYs after 2003 by increasing the State's DSH allotment for the previous FY by the percentage change in the CPI–U for the prior FY, subject to the 12 percent limit. This is the methodology as would otherwise have been applied under section 1923(f)(3)(A) of the Act, notwithstanding the application of the provisions of MMA. The fiscal year specified, is the FY in which the parallel DSH allotment calculated under this special parallel process equals or exceeds the FY 2004 DSH allotment, as determined under the MMA provisions. Once the fiscal year specified occurs for a State, that State's FY DSH allotment will be calculated by increasing the State's previous actual FY DSH allotment (which would be equal to the FY 2004 DSH allotment) by the percentage change in the CPI–U for the previous FY, subject to the 12 percent limit. The following example illustrates how the FY DSH allotment would be calculated for FYs after FY 2004.

Example—In this example, we are determining the parallel FY 2009 DSH allotment. A State's actual FY 2003 DSH allotment is $100 million. Under the MMA, this State's actual FY 2004 DSH allotment would be $116 million ($100 million increased by 16 percent). The State's DSH allotment for FY 2005 and subsequent FYs would continue at the $116 million FY 2004 DSH allotment for FYs following FY 2004 until the fiscal year specified occurs. Under the separate parallel process, we determine